A HEALTH PLANNER'S PERSPECTIVE* ON FOR-PROFIT MEDICINE

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PLANNERS are by nature social cost accountants. We like to know who benefits and who pays. That approach seems an appropriate strategy for evaluating the growing role of profit making institutions in health services. The purpose of such an evaluation is not to say that profit making is good or bad; rather the goal is to understand the implications of that growth for the broader social concerns that are the traditional focus of health policy. To that end I propose to analyze the growing for-profit health sector and to comment on its implications for universal access to good quality health care, the cost of that care, the scope of future medical research, and the ethics of medical care—the four areas which I view as the central focus of health policy. Based on that analysis, I suggest the direction which public policy must take to assure that the new for-profit providers fulfill important social goals as they maximize the return on their investment.

THE ROOTS OF THE PRESENT SYSTEM

The appearance of a new, vigorous, for-profit health sector, initially in the hospital field, and, more recently, in such newly emerging fields as free standing clinics and home care is the logical outcome of the strategy by which reform of the American health care system has progressed since the 1930s. While other nations opted for a comprehensive overhaul of medical care delivery, the United States, initially with leadership from the medical profession, opted for smaller financial reforms which permitted the physician-dominated system of care to survive farther into the era of technological medicine than would otherwise have been the case. It is worth recalling the key elements of that reform package, because the emerging for-profit health system is the progeny of those financial reforms.

The first reform was the development of Blue Cross and Blue Shield during the depression to insure that medical and hospital fees would be paid. This third party payment scheme took the extant health care system as given and

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added an insurance based reimbursement mechanism that did not interfere with the way in which the practice of medicine evolved under the guidance of the organized profession. An important result of the success of this cost-plus method of finance was that hospitals had the necessary cash flow to finance the initial adoption of the new technological innovations which began to appear at a rapid rate at the end of World War II.

Hill-Burton was the next major boost to the evolving health system. Third party money assured the cash flow to those already in the hospital business. Under Hill-Burton the federal government essentially advanced the front end capital for entry into that business. The result was an expansion of hospital beds.

The passage of Medicare and Medicaid in the middle 1960s—using the same model of cost-plus, third party payment pioneered by the blues—insured that virtually everyone had access to the health service system. From a provider point of view, the beauty of the system was that it never looked at the service provided or the way in which it was organized. Rather, it grafted an open-ended funding mechanism on to it. That funding mechanism was tied to the enormous taxing power of the federal government. The result, to no one's surprise, was that the cost in the cost-plus system exploded. No matter how fast general inflation ran, health care inflation ran faster.

Given the large open-ended funding that began to shape the health system, it was only a matter of time before a few entrepreneurs familiar with health care began to connect the industry to private capital markets. That return on investment is a reimbursable cost of the Medicare program virtually guaranteed the creation of hospitals where "rate of return" had nothing to do with patient status.

Profit Maximization as Public Policy

Before turning to an analysis of the implications of for-profit medicine, it is important that we understand the implications of the term "for profit." Simply put, profit is the difference between revenues and costs. When viewed in this straightforward manner, it is difficult to get caught in an ideological debate in which one side views profit making as inherently evil and the other side views it as a sign that an invisible hand guides us to noble purposes. Rather let us start from the pragmatic position that it is the result of two simultaneous activities carried on by business firms: minimization of costs and maximization of revenues. There are three strategies by which firms can lower costs: they can use resources more efficiently, they

can pay less for their purchases, or they can develop a strategy to avoid the costs altogether. Revenues can be increased by expanding services or increasing prices. Typically, firms adopt a profit-making plan comprised of elements from all these cost and revenue strategies. The exact mix depends upon the situation in which the firm finds itself. There is nothing inherently good or bad in these strategies; it all depends on how they are carried forward.

Cost Strategies and For-Profit Health Care

Perhaps the best known problem of our health care system is that costs continue to rise faster than the general inflation rate. The cost of hospital care is a major component of this pressure. One of the principal promises that for-profit hospitals hold out to the public is that they will be able to contain this cost pressure. The argument is that their profit motivation will make them sensitive to anything which boosts costs. Given a management team with an eye on "the bottom line," hospital resources will be used as sparingly and effectively as possible.

In addition to efficient management, they can also be expected to pursue a strategy of lowering the costs of the health system's two most expensive components, labor and physician autonomy. To the fullest extent possible, for-profit hospitals will avoid labor unions. To date, most of these hospitals are in areas where prolabor sentiment is weak and hospital unions virtually nonexistent. Large hospital chains can and will spend large sums to keep their work environments union-free even when they move into areas with a stronger tradition of union organization. Barring any upsurge in labor militancy or an invigorated national labor leadership, labor costs can be expected to be kept to a minimum. However, it is important to follow this situation closely because it could change more quickly than many people realize, in which case for-profit hospitals could find themselves in a serious economic squeeze if DRG administrators hold fast on reimbursement.

The second part of their cost-lowering strategy involves treating physicians as well paid employees rather than as autonomous professionals. Many observers have argued that the ability of physicians to order and to administer procedures to patients without sensitivity to costs is a major factor in health care inflation. For-profit hospitals will virtually end physician dominance of medical care as cost conscious administrators make many of the crucial policy decisions which circumscribe medical care protocols. In 1982, for the first time, most American physicians earned at least part of their incomes through salaried employment. The transformation of physicians into salaried employees will take on its most traditional form in for-profit hospitals.

If history provides any indication, the shift will be in two stages. At first, physicians will be given great leeway. Later, the discipline of salary dependence will shape the relationship. To the extent that physician work style contributes to cost pressure, for-profit hospitals will clearly be able to reduce that pressure.

The final method by which costs can be lowered is to avoid them altogether. In the case of for-profit hospitals, the fear is that these hospitals will cut corners in patient treatment. This fear is most often voiced as we move toward a regime of DRGs. It is sometimes charged that these hospitals would, under a fixed payment reimbursement scheme, attempt to provide as little service as possible. While I think they would try to avoid unnecessary costs, I do not think that they would stint as much on tests and procedures as some critics fear. Many of them are not as expensive on a marginal cost basis as they appear to be under the present regime of cost-plus reimbursement. Consider the case of diagnostic radiology. For-profit hospitals generally have all the latest equipment and staffs to operate it. Therefore, the cost of any individual procedure really amounts to a little electricity and film. Weighed against the cost of a potential malpractice suit, any good old fashioned "cover your butt" administrator will require the procedure.

It is sometimes charged that for-profits will avoid the social burden of caring for the poor. While it is obviously true that a profit making health center can have little use for people who cannot pay their bills, it is not immediately clear to me why we should ask them to shoulder a social burden the rest of society has been trying to avoid. The argument that voluntary hospitals at least provide some cross-subsidization of the poor is sometimes raised as a reason to oppose the movement toward for-profit health care. My impression is that the voluntary sector does as little of that type of care as possible. Voluntary hospitals have been hard pressed in recent times to make ends meet and have attempted to maximize paying customers and to minimize the uninsured. The larger issue here is whether we really have a social commitment to caring for the poor. If so, let us fund it in a straightforward manner. Or, if we do not, let us be honest about it and take the consequences. In either case let us not use the for-profits as a scapegoat for our collective failures.

Revenues in For-Profit Institutions

Compared to cost reduction, revenue raising is simpler to understand even

if it is not that much simpler to implement. Basically, there are two ways to increase revenues: expand services or raise prices or, better yet, do both! In terms of service expansion, it is impossible to predict the particular ways in which for-profit institutions will alter the menu of hospital services. To the extent that most hospital revenues are generated in the first three days of a patient's stay, it will probably be the case that hospital marketing strategy will focus on a caseload characterized by intense use of highly technical procedures and a quick turnover of beds. This assumes, of course, that the demand for beds exceeds the supply. In cases where hospitals have excess capacity, one would expect to see a willingness to take on patients with conditions requiring nursing care and longer confinements. We can safely assume that for-profit hospitals will adapt their strategy to suit the market condition in their area given their sensitivity to revenue conditions. In terms of the needs of individuals for care, this behavior can prove problematic and will therefore require some regulation to insure that for-profit hospitals adequately meet the needs of the areas which they serve.

In terms of raising prices, if we can insure that the market is highly competitive, the cost inflation of recent years would abate somewhat but not disappear. Hospitals will always want to charge as much as possible. To the extent that competition between hospitals can be turned into price competition, we could expect that under a regime of DRGs, prices would increase less rapidly than in the past. Prices will not fall, however, even if hospitals are superefficient. Since the drop in cost would translate into profit, it would quickly be capitalized into the asset structure of the hospital and become an element of cost. Only if price competition is very vigorous would cost savings eventually reduce prices. I think such vigorous competition unlikely. It would require far more excess capacity than any area is likely to tolerate, and it would waste more capital than prudent managers would be willing to venture.

The Four Health Policy Issues

In the first part of this paper I identified four areas of policy which I think must be monitored as for-profit medicine expands. Based on the previous discussion, two of the concerns are obvious.

For-profit hospitals will not serve the poor. They never were so intended. However, under any system the reality is that we have to make a special effort to serve the poor. In the present case, I advocate a federal tax on for-profit hospitals earmarked to reimburse those providers who do care for poor people. The tax should be federal because the poor and the rich do not cluster proportionately in the same geographic areas.

For-profit hospitals will likely slow the rate of cost inflation but will not reverse it. The coming of DRGs will work very well in the environment of for-profit medicine. Once the rules become clear, I have no doubt that institutions with an obligation to investors will insure that they can deliver care within the limits set even by a bureaucracy willing to be tough with enforcement. I would note in passing that Relman and others[1-4] have observed that for-profit hospitals tend to have higher costs because they undertake more procedures than the voluntaries. This is often cited as proof that they are really not cost saving after all. I read that evidence in a different way: it only proves that they are competent profit maximizers. Given cost-plus reimbursement, it is only good economic sense to bill as much as possible. The voluntary hospitals do not seem to maximize revenue so well. However, if the reimbursement rule becomes one based on average cost, as with DRGs, I think that the strategy will change. These hospitals are designed from the ground up to be able to adapt and to respond well to a finance driven regulatory policy such as has been the American Treatment of choice for the last five decades.

Given the profit orientation of these institutions, they will not engage in basic research. On the other hand, they will very quickly adopt any new, sound innovation to come out of the research centers. They will be very discerning consumers of new research once it has proved therapeutic or cost saving value. If such value exists, for-profit hospitals will be quick to adopt the innovation. The only exception to this would be where a new inexpensive technique replaces a more expensive procedure before the capital costs of that procedure have been fully amortized even if it is more therapeutically effective. In that case, there would be more reluctance to use the new innovation. That is, after all, the nature of profit making behavior, but over time the newer technology will be put in place. The time for adoption will in turn depend upon the degree of competition among hospitals. To the extent that a particular hospital has a monopolistic position, it will be less likely to adopt a new innovation if it undermines older investments. The only research that for-profit hospitals might support would be research that could lead to patentable or proprietary information which could be profitably exploited, much as is done by the drug industry today. Consequently, it will be necessary to continue public support for research under a regime of for-profit medicine, or basic research will suffer greatly.

The final area of concern is perhaps the most important and yet the least tangible: professional ethics. There is always a built-in tension when an individual attempts to serve two masters. In this case, the pull is between profitable behavior and good health care. This is not to say that the two are

incompatible. Indeed, a case can be made that in the long run good care is the most profitable strategy. On the other hand, life in the short run can at times be more complex. Do not misunderstand, the dilemma is not as dramatic as it might at first appear. I assume that in any life threatening case, profits would take a back seat to good medical practice. My concern is rather with the shades of gray that are more typical of day-to-day practice. The usual situation in medical care is uncertainty. In many cases it is not clear whether a particular intervention was correct or whether a different treatment strategy might have been more effective or perhaps it may have been best if no treatment at all was given. If the situation is complicated by concern with enterprise profitability, such tension will, over time, erode the quality of medical practice in ways that are not apparent if we just examine day-to-day medical decisions. On the other hand, in the complex world of health care as it exists today there are many ethically ambiguous situations and we manage to muddle through. Nonetheless, if for-profit medicine is to proceed, pressures would be sufficiently increased that strict standards of professional practice would have to be enforced by public agencies.

The Larger Issues

If I had my choice about the entire situation, we would not be discussing the kinds of policy problems which for-profit medicine will cause. Rather we would be discussing the further improvement of an integrated health system. It would be a system organized around a professional work force with well designed educational and career ladders rather than the present fragmentation into a series of psuedo professions which are really dead end jobs. The system would revolve around a set of well planned and located long and short-term care facilities linked to good home care services and connected to a network of national research and education centers. Employees would be salaried and would work in an environment motivated by a strong sense of professional ethics and pride. But I do not have that choice. The problem which confronts me as a planner is how to make the amalgam of patched together and finance driven services we have evolved do the job society needs done?

The issue is presented by most analysts as a choice between heavy regulation and the market. I see that as both a simple minded and wrong understanding of the matter. As I have tried to make clear, the irony is that the more we turn to the market, the more we will have to turn to tight regulation to make it work. The market is proclaimed because it is a self-adjusting

mechanism, but the adjusting device within that mechanism is profit. Profit making is a residual. It may be compatible with good medical care or it may not be. It is a much more complex matter than market advocates would have us believe. When it comes to issues of health and life, I dare say no one here would want to have their lives on the line in an ambiguous situation where good care and profits may or may not be compatible.

If heavy regulation is repugnant, one alternative is to establish a system of checks and balances. In the case of the health system, the best check, unfortunately, appears to be the malpractice lawyer. Hence, if we decide to expand for-profit medicine and find regulation distasteful, I would propose that we fund medical malpractice training programs in law schools around the nation. Then, using contingency fee practice, I would turn lawyers loose to oversee the profit maximizing health providers. True, it would be a costly solution, but so would regulation and so would nonregulation. The difference would be whether the costs are financial or borne by victims of poor practice. I am sure that either checks and balances, market regulation, or a well planned health care system would do the job. Which do we want?

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